
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Aetna at www.aetna.com/united or 1-800-334-0110 or BCBSIL at www.bcbsil.com/united or 1-800-535-9825. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call your carrier (Aetna: 1-800-334-0110 or BCBSIL: 1-800-535-9825) to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>In-Network: \$300/Individual or \$600/Family Out-of-Network: \$600/Individual or \$1,200/Family</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care, primary care services, and prescription drugs are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>In-Network Medical: \$2,000 Individual/\$4,000 Family Out-of-Network Medical: \$4,000 Individual/\$8,000 Family In-Network Prescription Drug: \$7,100 Individual/\$14,200 Family Out-of-Network Prescription Drug: Not applicable</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See https://member.accolade.com/ or call 1-844-252-6830 for a list of participating providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference</p>

		between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without a referral .

[* For more information about limitations and exceptions, see the plan or policy document for Aetna at www.aetna.com/united and for BCBSIL at www.bcbsil.com/united.]

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay ; deductible does not apply	40% coinsurance	————none————
	Specialist visit	\$40 copay ; deductible does not apply	40% coinsurance	————none————
	Preventive care/screening/immunization	No charge	40% coinsurance	Copays apply to all allergy tests and treatments. 20% coinsurance for allergy injections. Check with plan for details in-network. You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	————none————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com or call 1-844-635-3401	Generic drugs	Retail: \$10 copay Mail/CVS Pharmacy: \$25 copay Deductible does not apply.		Mandatory 90 day supply for maintenance medications through mail or CVS pharmacy.
	Preferred brand drugs	Retail: \$30 copay Mail/CVS Pharmacy: \$75 copay Deductible does not apply.		Up to three fills at retail allowed for maintenance medications.
	Non-preferred brand drugs	Retail: \$50 copay Mail/CVS Pharmacy: \$125 copay Deductible does not apply.		Retail – 30 day supply Mail/CVS Pharmacy – 90 day supply
	Specialty drugs	30% coinsurance		CVS Caremark is the pharmacy for specialty medications. \$0 copay for applicable specialty medications for members enrolled in PrudentRx Copay Program. Some medications such as self injectables are not covered in the

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				medical plan. Contact plan for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	————none————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————none————
If you need immediate medical attention	Emergency room care	\$200 copay ; deductible does not apply	\$200 copay ; deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————none————
	Urgent care	\$50 copay ; deductible does not apply	40% coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	————none————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay ; deductible does not apply	40% coinsurance	————none————
	Inpatient services	20% coinsurance ; deductible does not apply	40% coinsurance	————none————
If you are pregnant	Office visits	\$25 PCP copay ; \$40 specialist copay ; deductible does not apply	40% coinsurance	Copay is applicable for the first visit, subsequent visits are covered at 100%.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 40 visits per year. Must be noncustodial.
	Rehabilitation services	\$25 PCP copay ; \$40 specialist copay ; deductible does not apply 20% coinsurance for facilities	40% coinsurance	Unlimited visits/year. Medical necessity review required after the 25 th visit. Includes physical therapy, speech therapy, and occupational therapy.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	\$25 PCP copay ; \$40 specialist copay ; deductible does not apply 20% coinsurance for facilities	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	120 day limit per year. Must be noncustodial.
	Durable medical equipment	20% coinsurance	40% coinsurance	Must be medically necessary.
	Hospice services	20% coinsurance	40% coinsurance	—————none—————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not applicable
	Children's glasses	Not covered	Not covered	Not applicable
	Children's dental check-up	Not covered	Not covered	Not applicable

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care
- Non-emergency care when traveling outside the U.S.
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (with limitations)
- Bariatric surgery (IOQ facilities (Aetna) or Blue Distinction Centers (BCBS) only)
- Chiropractic care (limited to 30 visits per year)
- Hearing aids
- Infertility Treatment (covers diagnosis & treatment of infertility with limitations--does not cover in vitro fertilization)
- Private-duty nursing

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Aetna: **1-800-334-0110** or BCBSIL: **1-800-535-9825**.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al Aetna: **1-800-334-0110** or BCBSIL: **1-800-535-9825**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Aetna: **1-800-334-0110** or BCBSIL: **1-800-535-9825**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 Aetna: **1-800-334-0110** or BCBSIL: **1-800-535-9825**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' Aetna: **1-800-334-0110** or BCBSIL: **1-800-535-9825**.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$300
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like: [Specialist](#) office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,870

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$300
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like: [Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$800
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$300
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like: [Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900